



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

UVALDE BONE & JOINT CLINIC  
P O BOX 421389  
DEL RIO EX 78842-1389

#### **Carrier's Austin Representative Box**

Box Number 54

#### **MFDR Tracking Number**

M4-11-4866-01

#### **Respondent Name**

TEXAS MUTUAL INSURANCE COMPA NY

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** [Referring to timely filing of the medical bill to the workers' compensation insurance carrier.] "The above referenced claim was denied for timely filing, however, this is incorrect. Patient was originally a self-pay patient. On 11/02/10 I received a call from patient's employer who stated this should be covered by Workers Compensation. I then filed claim on 11/03/10. I called Texas Mutual Insurance on 12/03/10 and per automated system claim denied for timely filing, however this is incorrect as patients employee did not provide us with workers compensation information until 11/02/10 which caused a short delay."

**Amount in Dispute:** \$6,020.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The disputed dates of service are 6/22/10, 6/24/10, and 7/6/10. Rule 133.307 indicates a request for medical fee dispute resolution must be filed no later than one year from the disputed date of service. One year from 6/22/10 is 6/22/11, 6/24/10 is 6/24/11, and 7/6/10 is 7/6/11. The DWC MDR date stamp on the requestor's DWC-60 packet is 8/19/11, a date greater than one year from any of the disputed dates. Consequently, the request is out of jurisdiction and should be dismissed—not just \$0.0 ordered amount but dismissed."

**Response Submitted by:** Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, Texas 78723

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 22, 2010, June 24, 2010 and July 6, 2010	99284, 24545, 24579, Q4006, 29065, 73070, J1885, 96372	\$6,020.00	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated December 6, 2010

- CAC-18 – DUPLICATE CLAIM/SERVICE.
- CAC-29 – THE TIME LIMIT FOR FILING HAS EXPIRED.
- 224 – DUPLICATE CHARGE.
- 731 – PER 133.20 PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95<sup>TH</sup> DAY AFTER THE DATE THE SERVICE, FOR SERVICES ON OR AFTER 9/1/05.

### **Issue**

1. Did the requestor waive their right to medical fee dispute resolution?

### **Findings**

28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. ... A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." Review of the documentation finds that the request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on August 19, 2011, and that the dates of service in dispute are June 22, 2010, June 24, 2010 and July 6, 2010. No documentation was found to support that the dispute was timely filed to the MDR section, nor did the Division find that the disputed services involved issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section, consequently waiving its right to medical fee dispute resolution.

### **Conclusion**

The Division finds that the requestor waived its right to medical fee dispute resolution in this case. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Signed,

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Signature

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Medical Fee Dispute Resolution Officer

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October 28, 2011

Date

### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**